STATE OF NEW HAMPSHIRE

OFFICE OF THE GOVERNOR

JEANNE SHAHEEN
GOVERNOR

May **21,1998**

Honorable Donna E. Shalala, Secretary
Department of Health and Human Services
200 Independence Avenue, Southwest
Washington, DC **20201**

Dear Secretary Shalala:

I am pleased to submit to you New Hampshire's state plan to implement Title XXI of the Social Security Act. Improving access to health care coverage for all New Hampshire residents - especially children - has been one of my long-standing objectives. I would like to extend my appreciation to President Clinton and to Congress for their leadership on this issue of National importance. I also want to thank the staff of the Administration for their support in assisting states in the development and implementation of this exciting program.

New Hampshire's Title XXI plan builds on two programs that work well for us, specifically, the New Hampshire Medicaid program and the New Hampshire Healthy Kids program. Major plan features include:

- Extending Medicaid coverage for children ages zero to one in families with incomes up to **300** percent of the federal poverty level, and

- Purchasing health care coverage for children ages one to nineteen in families with incomes up to 300 percent of the federal poverty level through the New Hampshire Healthy Kids Corporation.

We are proud of our plan as it builds on existing, successful programs; enhances public-private partnerships and allows New Hampshire to be creative in its approach to outreach and enrollment strategies. We also recognize that this is but one step of many in achieving our goal of ensuring access to quality health care for all who call New Hampshire home.

Thank you again for all of your hard work. I look forward to a positive response to New Hampshire's Title XXI plan. The contact person for our plan is Kathleen Sgambati, Deputy Commissioner, Department of Health and Human Services, telephone **603-271-4600.**

Sincerely,

STATE HOUSE, **CONCORD, NH** 03301 (603)271-2121
TDD *Access:* Relay **NH** 1-800-735-2964

APPLICATION FOR STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT STATE CHILDREN'S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory: New Hampshire

As a condition for receipt of Federal funds under Title XXI of the Social Security Act,

(Signature of Governor of State/Territory, Date Signed)

submits the following State Child Health Plan for the State Children's Health Program and hereby agrees to administer the program in accordance with the provisions of the State Child Health Plan, the requirements of Title XXI and XIX of the Act and all applicable Federal regulations and other official issuances of the Department.

State of New Hampshire Title XXI Application
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Section 1. General Description and Purpose of the State Child Health Plans (Section 2101)

The state will use funds provided under Title XXI primarily for (Check appropriate box):

1.1. Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (**Section 2103**); OR

1.2. Providing expanded benefits under the State's Medicaid plan **(Title XIX)**; OR

1.3. [x] **A** combination of both of the above.
*New Hampshire's expansion of children's health care coverage under Title XXI will occur in **two** phases and will include both providing expanded benefits under the State's Medicaid plan and obtaining coverage that meets the requirements for a State Child Health Insurance Plan. This application requests authorization for both phases of the plan.*

*In Phase I (to be implemented May **1998**)[1] the state will expand Medicaid to include newborns and infants from birth to age 1 with family income greater than **185%** and equal to or less than 300% of the federal poverty level (FPL). Income will be calculated in the same manner currently used by the state for poverty level children (children with family income at or below **185%** of FPL) with an additional disregard of **65** percentage points of the FPL for the family size involved as revised annually in the Federal Register. In no case will income be disregarded such that the resulting net income is less than or equal to **185%** FPL. The federal eligibility standard is **235%** FPL. The state will be submitting a Title XIX plan amendment under separate cover.*

*In Phase 11 (to be implemented in January **1999**), the state will provide insurance coverage through the development of a State Child Health Insurance Program in partnership with the New Hampshire Healthy Kids Corporation (Healthy Kids Corp.) for children ages 1 through **19** with family income greater than **185%** and equal to or less than 300% of FPL . Income will be calculated in the same manner currently used by the state for poverty level children (children with family income at or below **185%** of FPL) with an additional disregard of **65** percentage points of the FPL for the family size involved as revised annually in the Federal Register. In no case will income be disregarded such that the resulting net income is less than or equal to **185%** FPL. The federal eligibility standard is **235%** FPL. The plan includes an emphasis on perinatal care coverage for pregnant adolescent girls not previously served by the Healthy Kids Corp. It also provides a mechanism for the identification and referral **of** children with special health care needs to Title V programs.*

See Appendix 1.3 for a chart outlining the approach.

[1] *New Hampshire recognizes that the enhanced Title XXI match will not be available for Phase 1 until this plan is approved by the Health Care Financing Administration.*

Section 2. General Background and Description of State Approach to Child Health Coverage (Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))

2.1. Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in section 2110(c)(2)). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships.

See Appendix 2.1.

2.2. Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: (Section 2102)(a)(2))

2.2.1. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs (i.e. Medicaid and state-only child health insurance):

Brochures outlining options for health care overage, including Medicaid eligibility as well as Medicaid applicationforms (New Hampshire has a short applicationform commonly referred to as the 800-P for poverty level children's groups and pregnant women) are available at a variety of community agencies and provider sites such as hospitals, WIC sites, and public health clinics and community health centersfunded through Title V and Title X grants. These same agencies are part of an on-going effort by the state to identify Medicaid eligible children and provide support to eligiblefamilies who up until now have not availed themselves of Medicaid benefits but would be eligible f they applied. The state provides Medicaid applicationforms and information on the voluntary managed care healthplans to Healthy Kids Corp. for distribution tofamilies whose children are likely to be Medicaid eligible. The state has alsofunded a researchproject via the Community Grants Project that is looking at barriers to enrollment in Medicaid. The results of this project will serve and inform the state as itfurther develops an enhanced outreach effort described in section 5.0 of this application.

Formal Medicaid application and intake sites include the twelve local New Hampshire DHHS district offices strategically located around the state. In addition, the Medicaid 800-P shortforms can be completed and submitted via the Title V agencies, Title X clinics, WIC sites, disproportionate share hospitals, Early Intervention sites and Federally Qualified Health Centers (FQHC's).

The state's voluntary Medicaid managed care option is offered by trained District Office staffthrough the local district offices. The District office staff function as enrollment counselors, offering the option to enroll in managed care (versus remaining in thefee-for-service program), explaining the rules, providing state-approved marketingpackages developed by the healthplans, and enrolling recipients who choose this option. The state also maintains a toll

free phone number and client service units in both the Medicaid Administration Bureau and the Division of Family Assistance to provide prompt answers to questions regarding eligibility and services.

At this time there is no other public health or state only insurance program for children.

2.2.2. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership:

The only health insurance program for children that involves a public private-partnership is New Hampshire Healthy Kids Corporation (Healthy Kids Corp.). In 1993, the New Hampshire Legislature passed the Healthy Kids Act (RSA 126:H) to address the growing problem of uninsured children. The Act created the New Hampshire Healthy Kids Corporation, a private non-profit, "deemed to be a public instrumentality and ... by the authority of the powers conferred by this chapter shall be deemed and held to be the performance of public and essential government functions of the state."

The state does not subsidize premiums at this time, but it provides finds for administration, marketing and outreach. The Corporation is governed by a seventeen member Board of Directors, includes six appointees of state government including the Department of Health and Human Services. State oversight includes a requirement for an annual report to the Governor, various Commissioners, and members of the Legislature.

The state created Healthy Kids Corp. to provide affordable health coverage and access to health care services for uninsured children. The program design and operations are consistent with the goals of Title XXI. As a public-private partnership, the goal has been to conduct multifaceted outreach and marketing, simplify the enrollment process, and design and operate a program that would avoid the stigma often associated with Medicaid.

The Healthy Kids Corp. plan provides comprehensive health and dental benefits which emphasize the preventive and primary care that children need to stay healthy and go to school ready to learn. Currently coverage is underwritten by Blue Cross Blue Shield of New Hampshire for health benefits including mental health benefits, and Northeast Delta Dental for dental benefits. Selection of the insurance carrier was conducted through a formal RFP process.

To be eligible for Healthy Kids, a child must be a full time resident of the state, not eligible for Medicaid, not enrolled in employment-related group health insurance in the past three months, and their family income cannot exceed 400% of the federal poverty level.

Efforts to identify and enroll children in Healthy Kids Corp. have been extensive. The Corporation has developed outreach partnerships with schools, child care agencies, health care providers. municipalities and community-

based social service agencies. Award-winning printed materials include postcards, posters, annual reports, brochures and flyers which are widely distributed and displayed throughout the state. The Corporation conducts an aggressive media campaign which has resulted in frequent coverage in newspapers, on radio and television; speaking engagements on public affairs programs, and public service announcements. The Corporation teams with businesses for promotion activities such as fast food tray liners and promotion cards stuffed in bags at retail outlets such as grocery stores, pharmacies and discount department stores.

Schools provide the largest source of referral (about 40%) where twice each year the school age population is blanketed with promotion information and school nurses display information and make direct referrals. Twenty percent of inquiries cite media as their source of information about the program. As the program becomes more well known, provider and word-of-mouth referrals are becoming more frequent. The Corporation tracks response to its various marketing and outreach activities for informed decision making about the most effective methods and messages. At the present time Healthy Kids Corp. estimates that it has reached over 12,000 families in New Hampshire.

See appendix 2.2.2 for an outline of the current Healthy Kids Corp. benefits package.

2.3. Describe how the new State Title XXI program(s) is(are) designed to be coordinated with such efforts to increase the number of children with creditable health coverage so that only eligible targeted low-income children are covered: (Section 2102)(a)(3)

The state will ensure through its screening and eligibility determination processes that only eligible, targeted, low-income children are covered by the Title XXI plan. The state will also ensure that there is a coordinated effort between the current state sponsored Medicaid program and coverage provided by its public-private partnership with Healthy Kids Corp., thereby maximizing resources and reducing duplication of effort. By using a single application and a single point of entry and eligibility determination, the state will ensure that those children eligible for coverage as funded by Title XIX or Title XXI, will be informed of their option to enroll and will receive the technical support necessary to complete the application process.

The state Division of Family Assistance is beginning the implementation phase of a new software program called New HEIGHTS in the district offices. The program utilizes a cascading logic that allows staff in the district offices to screen for eligibility for various Medicaid coverage groups as well as other public assistance programs. With the advent of Title XXI, efforts are underway to build into New HEIGHTS the logic required to automate the screening and referrals to Healthy Kids Corp. for those families who do not qualify for services funded by Title XIX or XXI but who could qualify for services provided by Healthy Kids Corp. These referrals will be for families whose income exceeds 300% FPL.

Section 3. General Contents of State Child Health Plan (Section 2101)(a)(4))

3.1 Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children (Section 2102)(a)(4)

As noted in Section 1.3 and described in the state's Medicaid state plan amendment, the state will use Title XXI funds to expand coverage for newborns and infants who are currently covered up to 185% FPL. Title XXI will allow the state to increase its income eligibility for infants ages 0 to 1 whose family income is greater than 185% and equal to or less than 300% of FPL. Income will be calculated in the same manner used by the state for poverty level children (children with family income at or below 185% of FPL) with an additional disregard of 65 percentage points of the FPL for the family size involved as revised annually in the Federal Register. In no case will income be disregarded such that the resulting net income is less than or equal to 185% FPL. The federal eligibility standard is 235% FPL. This Medicaid expansion will be considered Phase 1 of New Hampshire's Title XXI Children's Health Insurance Plan (NH CHIP).

To complement Phase 1, the state is instituting a name change for all of the children's Medicaid Programs. The new program will be called Kids Care PLUS It is hoped that changing the name of the program will reduce barriers due to stigma associated with Medicaid enrollment. Through Title XXI, families will have the option of enrolling their child in the fee-for-service program, in which case the infant will receive the current Medicaid benefits package; or the family can choose to enroll the infant in the existing Medicaid voluntary managed care program. The state currently contracts with 2 managed care plans: Matthew-Thornton Health Plan (which has just merged with Blue Cross Blue Shield of New Hampshire), and Tufts Health Plan. An infant eligible for Title XXI and enrolled in a managed care plan will enjoy the same benefits package as those currently participating in the voluntary program. One of the goals in providing coverage for infants through a Medicaid expansion is to provide infants with a rich and comprehensive benefits package to meet their complex needs during the first year of life. The focus will be on preventive and well-child care to give the child a healthy start.

Utilizing the provisions of Title XXI, the state will continue retroactive coverage, and implement cost sharing and guaranteed eligibility provisions for infants at greater than 185% FPL and equal to or less than 300% FPL (with the 65 percentage points income disregard) in Phase 1. Consistent with the current Medicaid fee-for-service program, the state will provide three (3) months of retroactive coverage for services received in the 3 months prior to application date for Title XXI as long as the services received are within the scope of benefits and as long as the infant met the eligibility requirements during those 3 months.

Cost sharing provisions include a $15 per child per month premium for all infants enrolled in Phase 1 whether in the fee-for-service or voluntary managed care program. Payment of premiums will commence with the month following the month of the eligibility determination. If a family chooses to disenroll during any given month and the premium has been paid, the health care coverage will continue until the end of that month. Premiums will be collected by the Healthy Kids Corporation under contract with the Department of Health and Human Services as a third party administrator for Phase 1.

In accordance with federal regulations, eligibility may be terminated after sixty (60) days due to the non-payment of premiums. The state will opt to waive payment for hardship and good cause. Good cause for non-payment of premiums shall exist when it is determined that either the recipient's family experiences a temporary or unexpected loss of income which prevents the family from paying the premium or if the recipient's family incurs an unexpected expense which prevents the family from paying the premium.

The state will enhance its current presumptive eligibility process to begin with Phase 1. Training for community health centers, Early Intervention Sites, Title V and Title X agencies and hospitals is scheduled to be completed in May. A plan to offer training at other non-traditional presumptive eligibility sites is under development. The state will guarantee eligibility for infants who enroll in the voluntary managed care program for six (6) months.

In Phase 2 of the NH CHIP plan, the state will provide insurance coverage to children between ages 1 and 19 whose family income is greater than 185% and equal to or less than 300% of FPL. Income will be calculated in the same manner currently used by the state for poverty level children (children with family income at or below 185% of FPL) with an additional disregard of 65 percentage points of the FPL for the family size involved as revised annually in the Federal Register. In no case will income be disregarded such that the resulting net income is less than or equal to 185% FPL. The federal eligibility standard is 235% FPL. Phase 2 will include health care services for pregnant adolescent girls. The state will purchase insurance for these children through Healthy Kids Corp., described in 2.2.2. To be consistent with Phase 1 and to differentiate this program from the non-subsidized Healthy Kids Corp. program, the Phase 2 program will be named Kids Care.

As noted in section 2.2.2, Healthy Kids Corp. currently contracts with Blue Cross Blue Shield of New Hampshire and Northeast Delta Dental. The coverage offered is a managed care product with a focus on preventive and well-child care. Healthy Kids Corp. selected Blue Cross Blue Shield and Northeast Delta Dental via a competitive bid process. The state will not require another competitive bid process until such time as their enrollment reaches a sufficient capacity to support a competitive bid process. This is estimated at 5,000 children.

At the time of enrollment for Phase 2, a family can choose a primary care provider (PCP) from the Blue Cross Blue Shield provider network. If a PCP is not chosen, the family will be contacted by Healthy Kids Corp. and assisted with the selection process. The family can submit the first month's premium, which will be collected by Healthy Kids Corp. on behalf of the state. Mental health benefits are accessed through a phone call to the Blue Cross Blue Shield Behavioral Health Network. Prior PCP authorization is not necessary to access the mental health or dental benefits.

The Healthy Kids Corp.'s current benefits package does not include a maternity benefit. As such, the benefits package will be amended to include maternity care for pregnant adolescents. The state opts to bear full risk for the maternity benefit. As such the state will carry out a cost settlement after the adolescent has reached sixty (60) days postpartum.

The Healthy Kids Corp.'s current benefits package is not designed to address the comprehensive case management, care coordination and psychosocial supports that are needed by families in caring for a child with special health care needs. Services are required to ease the parental burden of caretaking responsibilities. In collaboration with community advisors, plans will be made to provide for the screening, referral and tracking of children with special health care needs. Coordination of resources will occur through the state's Special Medical Services Bureau, a Title V funded program that has the expertise to provide for the needs of these children.

Cost sharing provisions in Phase 2 are similar to Phase 1. A $15 per child per month premium will be implemented. Healthy Kids Corp. has made the premium payment process as user friendly as possible including mailing labels, change of address forms, use of coupon books and they are exploring electronic finds transfer for those families wishing to participate. Defaulting on the payment of premiums will result in the termination of eligibility after 60 days except for pregnant teens. Healthy Kids Corp. will report to the state children whose etigibility is terminated and the circumstances of the termination. Using the policy noted above in the discussion of Phase 1, the state will waive the premium for hardship/good cause. Six (6) month guaranteed eligibility will be available to children enrolled in Phase 2.

Pregnant teens will not have their eligibility terminated for failure to pay premiums until after the postpartum period. The default clock will begin on the sixty-first (61st) day postpartum. Terminating health care coverage mid-pregnancy is counter productive to the state's goal of healthy birth outcomes for mother and infant.

In addition to the monthly premium in Phase 2, a $5 co-pay for office visits and prescriptive drugs will be implemented along with a $25 fee for unauthorized or determined non-emergent use of an emergency room. Providers will be responsible for collecting the eo-pays at the time of service. The office co-pay will not apply to well-child or preventive health visits, dental check-ups, dental x-rays, cleanings and flouride treatments.

The state will include in its contract with Healthy Kids Corp., provisions for quality assurance, and data and reporting requirements as outlined in the section 7.0 and 9.0 of this application.

3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children: (Section 2102)(a)(4)

For children enrolled in Kids Care PLUS (Medicaid), the state will bear the responsibility for utilization controls. For infants in Phase 1 enrolled in the voluntary managed care program, the health plan conducts utilization reviews with state oversight. For children enrolled in Phase 2 in Kids Care via Healthy Kids Corp, the primary utilization control for covered services will be the responsibility of the managed care organization, specifically Blue Cross Blue Shield of New Hampshire. The contract with Blue Cross Blue Shield will include a definition of medical necessity and utilization management requirements, including clinical staffing requirements. The plan will be required to have written utilization management policies and procedures that include appropriateness criteria for authorization and denial of services and protocols for prior approval, hospital discharge planning, and retrospective review. All of the aforementioned is currently in place in the Medicaid voluntary managed care contract and will be applied to children covered under Title XXI.

Section 4. Eligibility Standards and Methodology. (Section 2102(b))

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. **(Section 2102)(b)(1)(A))**

4.1.1. [X] Geographic area served by the Plan: *Statewide*

4.1.2. [X] Age: *For Phase 1: Infants up to age 1.*
For Phase 2: Children between age 1 and 19.

4.1.3. [X] Income: *Family income must be greater than 185% and equal to or less than 300% of the FPL. Income will be calculated in the same manner as currently used by the state for poverty level children (children with family income at or below 185% of FPL) with an additional disregard of 65 percentage points of the federal poverty level for the family size involved as revised annually in the Federal Register. In no case will income be disregarded such that the resulting net income is less than or equal to 185% FPL. The federal eligibility standard is 235% FPL.*

Methods for evaluating income include pay check stubs, W-2s, income tax returns and letters from employers on company letterhead.

4.1.4. Resources (including any standards relating to spend downs and disposition of resources): *There will not be a resource/assets test.*

4.1.5. [X] Residency: To *be eligible a child must be a resident of the State of New Hampshire. There is no time requirement to be considered a resident.*

4.1.6. Disability Status (so long as any standard relating to disability status does not restrict eligibility.

4.1.7. [X] Access to or coverage under other health coverage: *Children who are eligible for Kids Care PLUS (Medicaid), are covered under a group health plan or other health insurance coverage, or are children of a public employee eligible for coverage under a state health benefits plan are not eligible. An application will be disapproved if it is determined that the child was covered under a health insurance plan within the last six months. However, an application may be approved for good cause. Such reasons include loss of employment, change of employment to an employer who does not provide dependent coverage, death of the employed parent, voluntary quit of employment, and the quit occurred for any of the good cause reasons specified in RSA 167:82 III (c) - (e) and discontinuation of coverage to all employees (regardless of income) by the employer.*

4.1.8. [X] Duration of eligibility: *In general, a child who has been determined eligible for Kids Care or Kids Care PLUS (Medicaid) and is enrolled in a managed care program in Phase 1 or Phase 2, shall remain eligible for 6 months*

unless the child attains the upper age limit, as appropriate, is no longer a resident of the state, or fails to pay premiums. Exceptions to this policy are previously noted.

The state may determine that an enrollee is not eligible if eligibility was a result of making a false statement, misrepresentation or concealment of or failure to disclose income or health insurance coverage. The state may recover payments made by the state on behalf of enrollees as a result of any false statement, misrepresentation, etc. regarding income or health insurance coverage.

Eligibility shall be redetermined not more than 12 months after the effective date of eligibility and annually thereafter.

4.1.9. Other standards (identify and describe):

There will be no other standards.

4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102)(b)(1)(B))

4.2.1. These standards do not discriminate on the basis of diagnosis.
4.2.2. Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.
4.2.3. These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3. Describe the methods of establishing eligibility and continuing enrollment. (Section 2102)(b)(2))

The state will create a single, seamless application process for Kids Care and Kids Care PLUS (Medicaid). For Phase 1 (May, 1998), families can continue to go to the established qualified sites or the local district offices to make application and have eligibility determined. In addition, the Medicaid 800-P short forms can be completed and submitted via the Title V agencies, Title X clinics, WIC sites, disproportionate share hospitals, Early Intervention sites and Federally Qualified Health Centers (FQHC's) per the state's presumptive eligibility process.

The state is also waiving the face-to-face interview requirement. With the implementation of Phase 2 the state will begin using a single application for both programs. The state will also establish a central unit within the Department of Health and Human Services where applications can be mailed. The Department will determine eligibility for both programs. This unit will be operational with the implementation of Phase 2 (January, 1999). The state will make applications available via the Department's web site.

Eligibility for Kids Care and Kids Care PLUS (Medicaid) will be determined based on information collected on the application form, which will include name, address, date of birth, social security number, residency, family income, employment, and insurance (both current and in the previous six months).

The state will verify address and income and whether the child is eligible for Kids Care PLUS (Medicaid). If the responses to questions regarding insurance coverage appear inconsistent, the state will contact the employer or insurer, as appropriate. If information is incomplete or questionable, the state will attempt to contact the applicant by phone to obtain missing information or to clarify questionable information within 10 business days of receipt of the application. If the family does not have access to a phone and/or if the state is not able to make contact by phone, the state will attempt to contact the family by mail. If no response is obtained within 10 days of sending a letter, the application will be denied.

The state will test for Medicaid eligibility first before determining eligibility for Kids Care. If a child meets Medicaid eligibility, he/she will be enrolled in Kids Care PLUS (Medicaid). This includes the option of enrolling in the voluntary managed care program. The state will serve as the enrollment counselor for these children, providing technical support during the enrollment process.

If a child is not eligible for Medicaid but is eligible for Phase 2 Kids Care (including income, residence, and insurance requirements), he/she will be enrolled in Title XXI via Healthy Kids Corp. If a child is not eligible for either program but may be eligible for the non-subsidized Healthy Kids Corp. program, the state will refer the child to Healthy Kids Corp.

Eligibility information for children determined eligible for Kids Care will be entered into the state system and sent to Healthy Kids Corp. Healthy Kids Corp. will complete enrollment, including sending a letter notifying the family of the child's eligibility (including the efsective date), materials about Healthy Kids Corp. and the health plan and a coupon payment book for premiums. Eligibility will be efsective the date a child is enrolled in a plan and payment received. This will generally be the first day of the month after the child was determined eligible but may be later if eligibility is determined within one week of the end of the month, if the premium is not received or if the family takes additional time to select a plan (if and when there is a choice of plans) or primary care provider.

Not more than 12 months after the efsective date of eligibility and annually thereafter, the state will re-determine eligibility for Kids Care and Kids Care PLUS (Medicaid). The state will mail a form to enrollees to obtain information necessary to redetermine eligibility. Also, as noted in section 4.1.8, enrollees will be required to notify Healthy Kids Corp. of any change in circumstance that could afsect continued eligibility for coverage. If the child is no longer eligible for Kids Care, he/she will be disenrolled. If he/she is eligible for Medicaid, he/she will be enrolled in Kids Care PLUS (Medicaid).

4.4. Describe the procedures that assure:

4.4.1. Through intake and follow-up screening, only targeted low-income children who are ineligible for either Medicaid or other creditable coverage are furnished child health assistance under the state child health plan. **(Section 2102)(b)(3)(A))**

As noted in section 4.3, the state will determine eligibility for both Kids Care and Kids Care PLUS (Medicaid). As part of the determination for Kids Care, the state will verify that an applicant is not a Medicaid beneficiary (through on-line access to the state's eligibility system). If the child is not a Medicaid beneficiary, the state will

(based on the information collected as part of the application process) determine whether he/she may be eligible for Medicaid (e.g., because of income level). If the child is already enrolled in Medicaid, the application for Kids Care will be denied. If the child appears likely to be eligible for Medicaid, the state will determine eligibility and assist in the enrollment of the child into Kids Care PLUS.

The application will include questions about insurance coverage. If a child has insurance coverage, he/she will not be eligible to receive coverage via Title XXI. Also, if a child has had insurance coverage in the past six months and does not meet one of the good cause exemptions (as noted in section 4.1.7), he/she will not be eligible to receive coverage via Title XXI. Children currently enrolled in Healthy Kids Corp. who meet the remaining eligibility guidelines, will be grandfathered into Kids Care.

4.4.2. That children found through the screening to be eligible for medical assistance under the state Medicaid plan under Title XIX are enrolled for such assistance under such plan. (Section 2102)(b)(3)(B))

The same state unit will determine eligibility for both Kids Care and Kids Care PLUS (Medicaid), which will maximize coordination of eligibility for both programs. The state will first determine whether or not a child is eligible for Kids Care PLUS (Medicaid). If the child is eligible, he/she will be enrolled. Only if he/she is not eligible for Kids Care PLUS (Medicaid) but is eligible for Kids Care via Healthy Kids Corp., will he/she be enrolled in Kids Care.

4.4.3. That the insurance provided under the state child health plan does not substitute for coverage under group health plans. (Section 2102)(b)(3)(C))

The application process will include collecting information about current coverage and coverage in the past six months. Children currently covered will not be eligible for Kids Care except for children currently enrolled in Healthy Kids Corp. who meet the remaining eligibility guidelines, will be grandfathered into Kids Care. The state will review applications to determine whether applicants or employers of applicants have discontinued private or employer-sponsored dependent coverage in order to participate in the program. Children who had employer-sponsored coverage within the previous six months who lost coverage for reasons related to the availability of Healthy Kids (e.g., no longer purchasing family coverage) will not be eligible. As noted in section 4.1.7, an application may be approved for good cause. Such reasons include loss of employment, change of employment to an employer who does not provide dependent coverage, death of the employed parent, voluntary quit of employment, and the quit occurred for any of the good cause reasons specified in RSA 167:82 111(c) - (e), and discontinuation of coverage to all employees (regardless of income) by the employer.

4.4.4. The provision of child health assistance to targeted low-income children in the state who are Indians (as defined in section 4(c) of the Indian Health Care Improvement Act, 25 U.S.C. 1603(c). **(Section 2102)(b)(3)(D))**

New Hampshire does not have any federally recognized tribes.

4.4.5. Coordination with other public and private programs providing creditable coverage for low-income children. **(Section 2102)(b)(3)(E))**

The state will coordinate with Healthy Kids Corp in the implementation of the Title XXI plan to the fullest extent possible to reduce duplication of efforts and to provide quality health care coverage to New Hampshire's uninsured children.

Section 5. Outreach and Coordination (Section 2102(c))

Describe the procedures used by the state to accomplish:

5.1. Outreach to families of children likely to be eligible for assistance or under other public or private health coverage to inform them of the availability of, and to assist them in enrolling their children in such a program: **(Section 2102(c)(1))**

The state, in partnership with Healthy Kids Corporation and other community health partners, will develop an outreach plan to ensure that New Hampshire families are aware of the child health insurance coverage options available under Title XXI as well as under Title XIX. The state will identify and build on the successful practices and efforts of its current Medicaid voluntary managed care program as well as those of Healthy Kids Corporation. The state will continue to use the district office staff located in the district offices to play a critical role in information sharing as well as the staff of Healthy Kids Corp. The plan will also capitalize on the collaborative relationships already developed by Health Kids Corp. with schools and child care centers as well as expanding the existing network of social service agencies and advocacy groups beyond those that have traditionally worked with the state and Healthy Kids Corp.

Outreach materials will include a variety of brochures, posters, flyers, and enrollment package materials. A broad based public awareness campaign will be designed and directed towards parents of uninsured children as well as educating the community at large. Information will cover the benefits offered, eligibility requirements, and how and where to apply. Campaigns will be conducted periodically to focus on boosting enrollment of specific target groups, such as developing materials to focus on infants. The outreach plan will take advantage of seasonal and geographic differences and events, such as the start of the school year. Campaigns will include cause-related marketing activities promoting child health such as immunization and lead screening outreach in addition to describing insurance options.

Other elements of the outreach plan will include:

- *distributing information through schools, child care centers, Head Start centers, WIC sites, community agencies and health care providers;*
- *providing displays for these sites and appropriate commercial establishments;*
- *use of fast food tray liners, milk carton side panels or retail bag stuffers;*
- *using public speaking engagements, talk shows, public affairs programs, news releases, press conferences, and radio and TV PSAs as appropriate;*
- *creating a special web site with links to both Healthy Kids Corporation's website and the DHHS website;*
- *conducting direct mail campaigns to demographically selected lists that match profiles of uninsured families, building on the current Healthy Kids mailing lists of previous inquiries as well as other providers lists;*
- *initial and refresher training of staff at all applications sites that provide one-on-one assistance on such topics as how to effectively deal with inquiries and potential members to maximize the contact as an enrollment opportunity; accuracy and completeness of the application; and referrals to other services; and,*
- *developing an evaluation methodology based upon the concepts of continuous quality improvement to ensure the efficient and effective use of outreach resources.*

Central to the state's goal of maximizing the enrollment of uninsured children will be our efforts to support speedy application and enrollment. Activities will include:

- *providing a toll-free telephone line to directly request brochures or other information packages and applications or to request assistance with completing an application no later than Phase 2;*
- *developing one application for both Kids Care and Kids Care PLUS;*
- *implementing a mail-in application process, including electronic mail no later than Phase 2; and*
- *increasing the availability of on-site application assistance at community based organizations utilizing staff trained in the eligibility requirements of the various public health and state benefit programs.*

5.2. Coordination of the administration of this program with other public and private health insurance programs: (Section 2102(c)(2))

As described in section 4, the state, in partnership with Healthy Kids Corp. is outlining roles and responsibilities for the administration of Title XXI not only to minimize duplication of effort but also maximize resources and capitalize on what each partner does best. As noted in section 9, the state is developing a methodology for including community advisors in the on-going monitoring of the administration of this program. The state is committed to integrating the Title XXI program into the operation of the current Medicaid program and other NH DHHS programs, by placing the primary responsibility for the daily operations of the Title XXI program into the managed care unit of the Medicaid Administration Bureau. This will enhance the referral process for children with special health care needs to the Special Medical Services Bureau as discussed in section 3.1.

Outreach will focus on health insurance for all uninsured children for both Kids Care and Kids Care PLUS (Medicaid). Information on both programs will be provided in all materials. The state has and will continue to develop relationships with other statewide health providers and insurance providers to familiarize them with Kids Care and Kids Care PLUS and will educate them in referral procedures. The state anticipates contracting with Healthy Kids Corp. for marketing and outreach services to compliment a comprehensive outreach plan that will be developed by the Department in collaboration with its community advisors.

Section 6. Coverage Requirements for Children's Health Insurance (Section 2103)

6.1. The state elects to provide the following forms of coverage to children:
(Check all that apply.)

6.1.1. Benchmark coverage; **(Section 2103(a)(1))**

6.1.1.1. FEHBP-equivalent coverage; **(Section 2103(b)(1))**
(If checked, attach copy of the plan.)

6.1.1.2. State employee coverage; **(Section 2103(b)(2))** (If checked, identify the plan and attach a copy of the benefits description.)

_____

6.1.1.3. HMO with largest insured commercial enrollment **(Section 2103(b)(3))**
(If checked, identify the plan and attach a copy of the benefits description.) _____

6.1.2. [X] Benchmark-equivalent coverage; **(Section 2103(a)(2))** Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach signed actuarial report that meets the requirements specified in Section 2103(c)(4). **See instructions.**

6.1.3. Existing Comprehensive State-Based Coverage; **(Section 2103(a)(3))** [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If "existing comprehensive state-based coverage" is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of **8/5/97** or one of the benchmark plans. Describe the fiscal year **1996** state expenditures for "existing comprehensive state-based coverage."

_____

6.1.4. Secretary-Approved Coverage. (Section 2103(a)(4))

6.2. The state elects to provide the following forms of coverage to children:
(Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) **(Section 2110(a))**

6.2.1. [X] Inpatient services **(Section 2110(a)(1))**

6.2.2. [X] Outpatient services **(Section 2110(a)(2))**

6.2.3. [X] Physician services **(Section 2110(a)(3))**

Including primary care providers such as Advanced Registered Nurse Practitioners and Physician Assistants.

6.2.4. [X] Surgical services **(Section 2110(a)(4))**

6.2.5. [X] Clinic services (including health center services) and other ambulatory health care services. **(Section 2110(a)(5))**

6.2.6. [X] Prescription drugs **(Section 2110(a)(6))**

Including all FDA approved, prescriptive contraceptive medicines and devices.

6.2.7. Over-the-counter medications **(Section 2110(a)(7))**

6.2.8. [X] Laboratory and radiological services **(Section 2110(a)(8))**

6.2.9. [X] Prenatal care and prepregnancy family services and supplies **(Section 2110(a)(9))**

6.2.10. [X] Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services **(Section 2110(a)(10))**

*Maximum of **15** days per year*

6.2.11. [X] Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services **(Section 2110(a)(11)**

Maximum of 20 visits per year

6.2.12. [X] Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) **(Section 2110(a)(12))**

Eyeglasses and hearing aids plus other DME **as** *determined to be medically necessary and consistent with diagnosis.*

6.2.13. [X] Disposable medical supplies **(Section 2110(a)(13))**

Disposable medical supplies as medically necessary and consistent with diagnosis, are covered.

6.2.14. [X] Home and community-based health care services (See instructions) **(Section 2110(a)(14))**

20 home health visits a year

6.2.15. Nursing care services **(Section 2110(a)(15))**

6.2.16. Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest **(Section 2110(a)(16)**

6.2.17. [X] Dental services (Section 2110(a)(17))

Diagnostic and preventive services are covered 100%. Restorative, endodontics and periodontics are covered at 50%. No orthodontics are covered,

6.2.18. Inpatient substance abuse treatment services and residential substance abuse treatment services **(Section 2110(a)(18))**

6.2.19. Outpatient substance abuse treatment services **(Section 2110(a)(19))**

6.2.20. Case management services **(Section 2110(a)(20))**

6.2.21. [X] Care coordination services **(Section 2110(a)(21))**
To be provided as part of the role of the Primary Care Provider.

6.2.22. [X] Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders **(Section 2110(a)(22))**

24 visits for speech therapy; 24 visits for occupational therapy or 24 visits for physical therapy or a combination of occupational and physical therapies.

6.2.23. [X] Hospice care **(Section 2110(a)(23))**

6.2.24. [X] **Any** other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. **(Section 2110(a)(24))**

Chiropractic services

6.2.25. Premiums for private health care insurance coverage **(Section 2110(a)(25))**

6.2.26. [X] Medical transportation **(Section 2110(a)(26))**

Emergency transportation by ambulance

6.2.27. [X] Enabling services (such as transportation, translation, and outreach services) **(Section 2110(a)(27))**

Non-emergent transportation will be available through the State's Medicaid Administration Bureau's transportation program. Enrollees must meet the program's requirements for reimbursement of transportation related expenses.

6.2.28. Any other health care services or items specified by the Secretary and not included under this section **(Section 2110(a)(28))**

Skilled nursing and rehabilitation facility services as deemed medically necessary and pre-authorized by the health plan.

Section 7. Quality and Appropriateness of Care

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. (2102(a)(7)(A))

Healthy Kids Corp. and their insurance subcontractor will be required to meet all standards for quality of care in the contract in order to contract with the state. The state will review and approve the subcontract agreement between Healthy Kids Corp. and the health plan prior to the enrollment of any children into Kids Care.

Once the state has signed a contract with Healthy Kids Corp, it will continuously monitor quality through various mechanisms, including: health plan contracting standards, reporting requirements, enrollee input, external reviews, and on-site reviews. The state will strive to establish a continuum across the Title XIX and Title XXI programs for quality e.g. contracting with the same External Quality Review Organization (EQRO), establishing priority areas for review and utilizing consistent measurement methodologies. The state will bear final responsibility for the quality improvement activities outlined in this application however, the quality improvement plan will be based upon a partnership with Healthy Kids Corp. and their contracted insurer.

The Phase I Kid Care PLUS (Medicaid) program will be monitored via the established quality improvement program in the Medicaid Administration Bureau, and more specifically within the Medicaid managed care unit. The established QIP includes the monitoring of quality and appropriateness of care and highlights well-baby and well child care. It is based upon this pre-existing program that the Phase 2 quality improvement program will be designed.

For Phase 2, the contract with Healthy Kids Corp. will include specific standards for quality of care, including the provision of well-baby care, well-child care, and immunizations that will be carried out by the health plan as their subcontractor. The health plan will be required to arrange for immunizations, physical examinations, health education, dental examinations/treatments and comprehensive screens (and any needed interperiodic screens) in accordance with the schedules recommended by the most current Recommended Childhood Immunization Schedule, United States and the American Academy of Pediatrics. The health plan will be required to have enrollees up to date on screening and immunizations within 3 months of being enrolled.

Reporting will include a report on the plan's quality improvement plan (QIP), HEDIS reports on immunizations and well child care, and other pediatric preventive health measures as part of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program, utilization reports, and periodic provider network reports. The state will require the subcontracted health plan to submit encounter data. The state recognizes that this information is crucial to the on-going monitoring and evaluation of the Kids Care program and will strive to develop a system that will receive, process and permit for detailed analysis, the scope of services provided to Kids Care enrollees. The state will work with Healthy Kids Corp. and the plan to develop the data elements, medium, format and time frames for submissions.

Other utilization information that involve health plan interventions and enrollee participation in activities such as complaints/grievance resolution, case coordination services, health risk screenings, disease management and health promotion programs will be reported and tracked.

Healthy Kids Corp. will be responsible for conducting enrollee satisfaction surveys. Healthy Kids Corp. may delegate this finction to the health plan. However, the state will review and approve the survey tool for specijic questions from the CAHPS instrument, sampling methodology, research design and final results. The state is also developing a provider satisfaction survey.

The finctions of the external quality review organization are described in section 7.1.1. In addition, the state will conduct periodic focus groups as part of its on-going community involvement process and maintains the option of conducting annual on-site evaluations at the health plan to assess compliance with contract requirements (such as utilization management decisions), and to establish, with the health plan, quality improvement projects and performance goals.

On-site reviews at the network provider level will be conducted based on provider profile information generated by encounter data for certain quality/utilization indicators, frequency of PCP changes and patterns of complaint and grievance data. As part of an on-site visit, enrollee medical records will be reviewed for the following:

- *evidence of the provision of access to care within contract standards,*
- *review of specific areas of care/treatment identijied as outliers (i.e. increased emergency department visits or asthma hospitalizations),*
- *medical decision making (management of a specijic diagnosis) and*
- *compliance with standard elements of documentation (i.e. comprehensive health risk screening).*

Review findings will be summarized, noting variances with criteria, standards and performance. Written reports with summary data, issues and recommendations will be submitted to Healthy Kids Corp., the health plan, the Commissioner's Consumer Policy Advisory Board and the Commissioner's Managed Care Advisory Committee.

Will the state utilize any of the following tools to assure quality?
(Check all that apply and describe the activities for any categories utilized.)

7.1.1. [X] **Quality standards**

The state will contract for an external quality review of the health plan. Such review shall include, but not be limited to, an evaluation of access to care, quality of care studies, medical record standards, and individual case review and appropriateness of care. All activities carried out by the EQRO will be prior approved by the state in order to assure appropriate monitoring and to assure consistency in quality improvement activities across programs.

7.1.2. [X] Perform-nce measurement

The state will require the health plan to submit HEDIS reports on immunizations, well child visits and other pediatric preventive health measures. The state will develop specific performance targets or required degrees of improvement on particular measures in conjunction with Healthy Kids Corp. and the health plan. The plan and the state will identify two (2) HEDIS measures under the Effectiveness of Care, Use of Services and or Access domains where improvement will be targeted. Within specijic time frames, the plan will achieve a benchmark level of performance defined and agreed to in advance or will achieve a reduction of at least ten percent (10%) in the number of enrollees who do not achieve the outcome defined by the indicator (or if applicable, in the number of instances in which the desired outcome is not achieved).

The state will adopt where possible the guidelines issued by HCFA under the Quality Improvement System for Managed Care (QISMC), as finalized, in its quality oversight system.

7.1.3. [X] Information strategies

The state, Healthy Kids Corp., and the health plan will be required to educate enrollees about their benefits under KIDS CARE and KIDS CARE PLUS as well as their rights and responsibilities. The plan will also educate enrollees about the importance of preventive services, health promotion activities, care coordination services, disease management programs, and visiting their primary care provider instead of an emergency room.

7.1.4. [X] Quality improvement strategies

The contract with Healthy Kids Corp. will include specijic standards for quality of care including access to care and appointment availability, and the health plan will have to meet those standards in order to contract with Healthy Kids Corp. and the state. These standards will be monitored by the state and Healthy Kids Corp. through reporting requirements, on-site reviews, external reviews and enrollee input through complaint data and satisfaction surveys. .

In particular, the plan will be required to establish an internal quality improvement plan (QIP), which will be in writing and available to the public. The written description shall include detailed goals and annually developed objectives; address the quality of clinical care and non-clinical aspects of services for the range of care provided by the plan; specify quality of care studies and related activities; provide for continuous performance of activities, including tracking of issues over time; and provide for review and feedback by physicians and other health professionals. By the end of the first contract year, the plan will be required to initiate two (2) clinical focused projects aimed at improving care for Kids Care enrollees. Clinical focus areas applicable to this target population include topics related to:

- *lead toxicity screening and treatment,*
- *chronic pediatric asthma,*
- *attention deficit disorder,*

- *adolescent counseling on smoking and substance abuse,*
- *well-child care,*
- *behavioral health screening and treatment and*
- *perinatal services.*

The state, Healthy Kids Corp. and the health plan will work collaboratively to select the clinical areas to be studied and define the improvement strategy.

An annual report on the QIP will be required. This report will be made in the form of a presentation to the state and its community advisors. In addition, the report will be made available as a formal written report that will be made available to the public as hard copy and on the DHHS website.

For Kids Care enrollees that become pregnant while eligible, comprehensive perinatal services shall be available and accessed through the contracted health plan. The plan's purchasing specifications must describe and demonstrate a comprehensive, proactive perinatal program with adherence to care guidelines as recommended by the American College of Obstetrics and Gynecology. HEDIS perinatal and birth outcome indicators will be utilized to measure and assess performance. Depending upon the results and trends, the health plan's QIP shall be expected to develop further interventions and strategies to increase participation and positive outcomes.

7.2. Describe the methods used, including monitoring, to assure access to covered services, including emergency services. (2102(a)(7)(B))

The state will require the health plan to include sufficient numbers of appropriately trained and certified clinicians of pediatric care, including primary, medical subspecialty and surgical specialty physicians, as well as providers of necessary related services such as dental and mental health services. The state will monitor network capacity through quarterly provider network reports and will suspend enrollment if capacity is exceeded.

The health plan will be required to ensure that their provider networks provide access to primary care providers (PCPs) within 20 miles/45 minutes and access to emergency services on a 24-hour, seven-day-a-week basis. Emergency care shall be provided immediately, urgent care within 24 hours, non-urgent, symptomatic PCP appointments shall be available within 48 hours from the enrollees request to be seen and non-symptomatic, routine/preventive care within 30 calendar days. An emergency medical condition will be defined as a condition such that a prudent lay person, acting reasonably, would have believed that emergency medical treatment is needed. The state and Healthy Kids Corp. will monitor access requirements through reporting and member satisfaction surveys.

Section 8. Cost Sharing and Payment (Section 2103(e))

8.1. Is cost-sharing imposed on any of the children covered under the plan?

8.1.1. [X] **YES**
8.1.2. NO, skip to question 8.5.

8.2. Describe the amount of cost-sharing and any sliding scale based on income: **(Section 2103(e)(1)(A))**

8.2.1. Premiums: *Children withfamily income greater than 185% and less than or equal to 300% of the FPL will be required to pay a premium of $15 per child per month. Premiumsfor Phase 1 and Phase 2 will be collected by Healthy Kids Corp. per a contract agreement to be entered into by the state and Healthy Kids Corporation.*

8.2.2. Deductibles: *Not applicable*

8.2.3. Coinsurance: *Not applicable*

8.2.4. Other: *For Phase 2, there will be a **$5** co-payfor provider office visits and prescription drugs. There will be a **$25** co-payfor non-emergent and unauthorized emergency room visits. There will be **no** co-payfor preventive health and/or well child visits, dental check-ups, dental x-rays, cleanings and flouride treatments.*

8.3. Describe how the public will be notified of this cost-sharing and any differences based on income:

*Information about premiums and co-pays will be included in the outreach/education materials. Both the state and Healthy Kids Corp. will provide, information **on** the cost sharing requirements to enrollees **as** well as to the provider community.*

8.4. The state assures that it has made the following findings with respect to the cost sharing and payment aspects of its plan: **(Section 2103(e))**

8.4.1. Cost-sharing does not favor children from higher income families over lower income families. **(Section 2103(e)(1)(B))**

8.4.2. No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. **(Section 2103(e)(2))**

8.4.3. No child in a family with income less than 150% of the Federal Poverty Level will incur cost-sharing that is not permitted under 1916(b)(1).

8.4.4. No Federal funds will be used toward state matching requirements. **(Section 2105(c)(4))**

8.4.5. No premiums or cost-sharing will be used toward state matching requirements. **(Section 2105(c)(5)**

8.4.6. No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. **(Section 2105(c)(6)(A))**

8.4.7. Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997.

(Section 2105(d)(1))

8.4.8. No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. **(Section 2105)(c)(7)(B))**

8.4.9. No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). **(Section 2105)(c)(7)(A))**

8.5. Describe how the state will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's annual income for the year involved: **(Section 2103(e)(3)(B))**

New Hampshire's selection of a $15 premium ensures compliance with the federal regulations. If that premium should change in the future, the state, through its eligibility and redetermination of eligibility processes, will ensure that the premium does not exceed five percent of a family's income and aggregate cost sharing for a family will not exceed five percent of such family's annual income for the year involved. The state and Healthy Kids Corp. will educate families on reporting changes in financial status, especially those that reduce family income.

8.6. The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan:

8.6.1. The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services **(Section 2102(b)(1)(B)(ii))**; **OR**

8.6.2. The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see section 6.3.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA **(Section 2109(a)(1),(2))**. Please describe if applicable.

Section 9. Strategic Objectives and Performance Goals for the Plan Administration (Section 2107)

9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: **(Section 2107(a)(2))**

The strategic objectives are to: 1) increase the number of low-income children in New Hampshire who are insured; 2) improve the health status of children in New Hampshire with a focus on preventive and primary care; 3) maximize participation in Title XXI through outreach, a single point of entry, a simplified application process, and continuous eligibility; 4) maximize coordination with Medicaid to ensure coverage of children previously eligible but not enrolled in Medicaid.

9.2. Specify one or more performance goals for each strategic objective identified: **(Section 2107(a)(3))**

1) Increase the number of low-income children in New Hampshire who are insured.

Decrease the proportion of children 1-19 ≤ 300% of FPL who are uninsured by 25% in the first year, 35% in the second year, 45% in the third year, and 50% in the fourth year.

2) Improve the health status of children in New Hampshire with a focus on preventive and primary care.

As noted in section 7.1.2, the state will require the health plan to submit HEDIS reports on immunizations, well child visits and other pediatric preventive health measures. The state will develop specific performance targets or required degrees of improvement on particular measures in conjunction with Healthy Kids Corp. and the health plan. The plan and the state will identify two (2) HEDIS measures under the Effectiveness of Care, Use of Services and or Access domains where improvement will be targeted. Within specific time frames, the plan will achieve a benchmark level of performance defined and agreed to in advance or will achieve a reduction of at least ten percent (10%) in the number of enrollees who do not achieve the outcome defined by the indicator (or if applicable, in the number of instances in which the desired outcome is not achieved). At a minimum the state will expect to address the following goals based on the strategic objectives in section 9.1.

Match or exceed the current statewide average percentage of children under two who receive the basic immunization series.
Match or exceed the current statewide average percentage of 13 year olds who receive the basic immunization series.
Match or exceed the current statewide average percentage of 3, 4, 5, and 6 year olds who have at least one well-child visit during the year.
Match or exceed the current statewide average percentage of 12 through 18 year olds who have at least one well-child visit during the year.

3) Maximize enrollment in Kids Care and Kids Care PLUS through outreach, a single point of entry, a simplified application process, and continuous eligibility

Increase the number of locations where individuals can get applications and receive assistance in completing applications.
Increase the number of entities participating in the outreach program.
Increase the percentage of applications requested that are completed.
Decrease the amount of follow-up required to complete applications.
Ensure that at least 75% of consumers are satisfied with the application process.

***4)** Maximize coordination with Medicaid*

Increase enrollment in Kids Care PLUS (Medicaid) by ten percent (10%) in the first year of operations.
Establish a seamless program with integrated staff and administration.

9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state's performance, taking into account suggested performance indicators as specified below or other indicators the state develops:
(Section 2107(a)(4)(A),(B))

1) Increase the number of low-income children in New Hampshire who are insured. This will be measured using CPS data sample.

2) Improve the health status of children in New Hampshire with a focus on preventive and primary care - The health plan(s) will be required to submit data on immunizations and well-child visits. The state will use these data to make comparisons to the current percentages.

3) Maximize participation in Kids Care and Kids Care PLUS through outreach, a single point of entry, a simplified application process, and continuous eligibility - Performance goals will be measured by collecting information on the number of locations that provide applications and assistance and that are involved in outreach and comparing that to current participation. The state will also conduct surveys regarding completed applications, follow-up, and satisfaction with the application process.

***4)** Maximize coordination with Kids Care PLUS (Medicaid) - The state will collect information on Medicaid enrollment through its eligibility system and compare it to current enrollment.*

Check the applicable suggested performance measurements listed below that the state plans to use: (Section 2107(a)(4))

9.3.1. [X] The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
9.3.2. [X] The reduction in the percentage of uninsured children.
9.3.3. [X] The increase in the percentage of children with a usual source of care.
9.3.4. [X] The extent to which outcome measures **show** progress on one or more of the health problems identified by the state.
9.3.5. [X] HEDIS Measurement Set relevant to children and adolescents younger than 19.
9.3.6. Other child appropriate measurement set. List or describe the set used.

9.3.7. If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:

9.3.7.1. Immunizations
9.3.7.2. Well child care
9.3.7.3. Adolescent well visits
9.3.7.4. Satisfaction with care
9.3.7.5. Mental health
9.3.7.6. Dental care
9.3.7.7. Other, please list: _____

9.3.8. [X] Performance measures for special targeted populations.

9.4. The state assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. **(Section 2107(b)(1))**

9.5. The state assures it will comply with the annual assessment and evaluation required under Section 10.1. and 10.2. (See Section 10) Briefly describe the state's plan for these annual assessments and reports. **(Section 2107(b)(2))**

The Department will perform the annual assessments and evaluations required under sections 10.1 and 10.2. The annual report will assess the operation of the Title XXI plan, including the progress made in reducing the number of uninsured children. The baseline number will be calculated using CPS data (although the sample size is very small). By March 31, 2000 the state will submit an evaluation of the items listed in 10.2. The state will contract with a consulting firm chosen via a competitive RFP process that has the expertise to conduct the evaluation and analysis. The evaluator will assist the state in determining how to analyze the effectiveness of various elements. However, characteristics of the children enrolled in the plan can be collected from the applicationforms, and quality will be evaluated using the measures identified in sections 7.1.2 and 9.3. Other elements may be analyzed based on surveys and interviews.

9.6. The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. **(Section 2107(b)(3))**

9.7. The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed.

9.8. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: **(Section 2107(e))**

9.8.1. Section 1902(a)(4)(C) (relating to conflict of interest standards)
9.8.2. Paragraphs (2), (16) and (17) of Section 1903(I) (relating to limitations on payment)
9.8.3. Section 1903(w) (relating to limitations on provider donations and taxes)
9.8.4. Section 1115 (relating to waiver authority)
9.8.5. Section 1116 (relating to administrative and judicial review), but only insofar as consistent with Title XXI
9.8.6. Section 1124 (relating to disclosure of ownership and related information)
9.8.7. Section 1126 (relating to disclosure of information about certain convicted individuals)

9.8.8. Section 1128A (relating to civil monetary penalties)
9.8.9. Section 1128B(d) (relating to criminal penalties for certain additional charges)
9.8.10. Section 1132 (relating to periods within which claims must be filed)

9.9. Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. (Section 2107(c))

A multidisciplinary group comprised of Department staff and representatives from the Governor's Office and Healthy Kids Corp. worked to develop and review the initial conceptual model. The Department met with the Healthy Kids Corp. Board of Directors on March 2, 1998, to review the proposed model and to solicit input into the plan. The Board membership includes representatives from the Department of Education, Department of Insurance, State Legislators, New Hampshire School Boards Association, New Hampshire Pediatric Society, New Hampshire School Nurses Association, New Hampshire Children's Alliance, New Hampshire Child Care Association, and the New Hampshire Hospital Association. Follow up meetings have been held with the Board of Directors. The Department also met with representatives from Blue Cross Blue Shield of New Hampshire.

Since that time a series of public meetings have been held. Each session included an overview of the Title XXI legislation and application requirements; a review of proposed conceptual plan; and a review of the proposed benefits package. In addition to providing time for commentary on the plan, time was spent on developing a long-term plan to ensure on-going public involvement. From each session a list of questions and answers as well as comments was generated and documented. Unanswered questions were followed up on by Department staff.

The public meetings included:

March 12, 1998	*The Commissioner's Managed Care Advisory Group and NH Child Action Team*
March 18, 1998	*Community Mental Health Centers Executive Directors*
March 19, 1998	*The Consumer Policy Advisory Board*
March 24, 1998	*A formal Public Hearing was held on the NH CHIP Plan*
March 27, 1998	*The Welfare Reform Advisory Group*
April 1, 1998	*The Medicaid Medical Care Advisory Committee*
April 10, 1998	*Child Health Coordinators of the Title V-funded Well Child Clinics and Primary Care agencies*
April 14, 1998	*Headstart Health and Nutrition Coordinators*
April 14, 1998	*RWJF Outreach Grant Participants*
April 15, 1998	*Health Planning District Council Meeting in Manchester*
April 16, 1998	*Health Planning District Council Meeting in Plymouth*
April 20, 1998	*A formal Public Hearing on rule changes for the NH CHIP Plan*
May 11, 1998	*NH DHHS Primary Care Steering Committee*
May 15, 1998	*Commissioner's Child Care Advisory Committee*
May 21, 1998	*NH Welfare Directors/NH Municipal Association*

In addition to the public meetings previously noted, the state created a site on the Department of Health & Human Services web page (www.state.nh.us/dhhs/deptlinks.htm). The web site includes information on the proposed plan and as each section of this application was drafted, it was added to the web page. A copy of the final working draft of the application was made directly available to a variety of advocacy groups and community leaders.

An outcome of the public meetings included a plan to ensure on-going public involvement. Several individuals indicated an interest in working through a variety of operational issues with the Department. These individuals were invited to attend workgroup meetings focused on eligibility and enrollment, benefits design including cost-sharing and outreach efforts. The outreach effort will be a part of a much larger Departmental outreach plan which will be developed with our community partners. This will prove vital if we are to reach the consumers directly and in a timely manner.

As suggested by advocates attending the public meetings, once the workgroups complete their tasks and the state moves into an implementation phase, the primary point of contact will be through the Commissioner's Managed Care Advisory Group, the Commissioner's Consumer Policy Advisory Board which have diverse representation and the Health Planning District Council meetings. The Healthy Kids Corp. Board of Directors has agreed to continue to play an on-going advisory role. The state will also maintain a point person in the Department of Health & Human Services who can be reached by mail, phone or email. The state will utilize its employee newsletter for updates on the NH CHIP plan and to invite purticipation at any focus groups or meetings scheduled on the plan. This newsletter enjoys a vast circulation beyond the state employees. Lastly, the state, upon approval of this application, will conduct a series of media activities including radio and television shows, as well newspaper and newsletter articles.

9.10. Provide a budget for this program. Include details on the planned use of funds and sources of the non-Federal share of plan expenditures. (Section 2107(d))

See Appendix 9.10

Section 10. Annual Reports and Evaluations (Section 2108)

10.1. Annual Reports. The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: (Section 2108(a)(1),(2))

10.1.1. The progress made in reducing the number of uncovered low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

10.1.2. Report to the Secretary, January 1 following the end of the fiscal year, on the result of the assessment.

10.2. State Evaluations. The state assures that by March 31,2000 it will submit to the Secretary an evaluation of each of the items described and listed below: (Section 2108(b)(A)-(H))

10.2.1. An assessment of the effectiveness of the state plan in increasing the number of children with creditable health coverage.

10.2.2. A description and analysis of the effectiveness of elements of the state plan, including:

10.2.2.1. The characteristics of the children and families assisted under the state plan including age of the children, family income, and the assisted child's access to or coverage by other health insurance prior to the state plan and after eligibility for the state plan ends;

10.2.2.2. The quality of health coverage provided including the types of benefits provided;

10.2.2.3. The amount and level (including payment of part or all of any premium) of assistance provided by the state;

10.2.2.4. The service area of the state plan;

10.2.2.5. The time limits for coverage of a child under the state plan;

10.2.2.6. The state's choice of health benefits coverage and other methods used for providing child health assistance, and

10.2.2.7. The sources of non-Federal funding used in the state plan.

10.2.3. An assessment of the effectiveness of other public and private programs in the state in increasing the availability of affordable quality individual and family health insurance for children.

10.2.4. A review and assessment of state activities to coordinate the plan under this Title with other public and private programs providing health care and health care financing, including Medicaid and maternal and child health services.

10.2.5. An analysis of changes and trends in the state that affect the provision of accessible, affordable, quality health insurance and health care to children.

10.2.6. **A** description of any plans the state has for improving the availability of health insurance and health care for children.

10.2.7. Recommendations for improving the program under this Title.

10.2.8. Any other matters the state and the Secretary consider appropriate.

10.3. The state assures it will comply with future reporting requirements as they are developed.

10.4. The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

Appendix 1.3
Chart Illustrating New Hampshire's Approach to Title XXI

CHILDREN'S HEALTH CARE COVERAGE EXPANSION

Phase I: MEDICAID EXPANSION

AGE	0-185% OF POVERTY	186 TO 235% OF POVERTY	236-300% OF POVERTY
CHILDREN AGES 0 TO 1	KIDSCARE PLUS (MEDICAID)	KIDSCARE PLUS (MEDICAID) *PREMIUM TO BE DETERMINED*	KIDSCARE PLUS (MEDICAID) *PREMIUM TO BE DETERMINED*

Phase II: TITLE XXI EXPANSION

AGE	0-185% OF POVERTY	186 TO 235% OF POVERTY	236-300% OF POVERTY
CHILDREN AGES 0 TO 1	KIDSCARE PLUS (MEDICAID)	KIDSCARE PLUS (MEDICAID)	KIDSCARE PLUS (MEDICAID)
CHILDREN AGES 1 TO 19	KIDSCARE PLUS (MEDICAID)	KIDSCARE (HEALTHY KIDS CORP) *PREMIUM TO BE DETERMINED*	KIDSCARE (HEALTHY KIDS CORP) *PREMIUM TO BE DETERMINED*
PREGNANT CHILDREN TO AGE 19	KIDSCARE PLUS (MEDICAID)	KIDSCARE (HEALTHY KIDS CORP) *PREMIUM TO BE DETERMINED*	KIDSCARE (HEALTHY KIDS CORP) *PREMIUM TO BE DETERMINED*

Note: Shaded areas indicate new coverage at each stage.

INFORMATION ON CHILD HEALTH COVERAGE

The following is based on March **1996** CPS data and state Medicaid eligibility data. Note that New Hampshire's CPS sample size is very small and does not support analysis of many factors. This is the only information that New Hampshire has currently (we do not have data by age or race/ethnicity), but the state is considering conducting surveys to supplement the **CPS** findings.

	XIX	Other Coverage	Total Insured	Uninsured	**TOTAL**
≤ 184%	**41,500**	**10,574**	**52,074**	**8,072**	**60,146**
185-199%	**0**	**15,553**	**15,553**	**849**	**16,402**
200-224%	**0**	**25,599**	**25,599**	**1,805**	**27,404**
225-249%	**0**	**20,093**	**20,093**	**841**	**20,934**
250-274%	**0**	**19,497**	**19,497**	**1,763**	**21,260**
275-299%	0	**16,946**	**16,946**	**0**	**16,946**
300-399%	0	**49,839**	**49,839**	**3,608**	**53,447**
≥ 400%	**0**	**95,382**	**95,382**	**2,227**	**97,609**
TOTAL	**41,500**	**253,483**	**294,983**	**19,165**	**314,148**

HEALTHY KIDS CORPORATION
Current Benefits Package

Administered by Blue Cross Blue-Shield of New Hampshire
Physician Services Office visits, Specialist visits, Physical exams
Well child office visit
Childhood immunization
Outpatient testing
Surgical services, Inpatient medical care
Inpatient Hospital Services
Skilled Nursing Facility and Rehabilitation Facility
Hospice Services
Outpatient Services
Home Health Services - 20 visits per year
Physical Therapy and Occupational Therapy - 24 visits per year
Speech Therapy - 24 visits per year
Outpatient Mental Health Services* - 20 visits per year
Inpatient Mental Health Services* - 15 days per year
Chiropractic Office Visits+
Eyeglasses+ - 1 routine eye exam per 24 months 1 pair per year (limited selection of frames)
Hearing Aids+ - 2 per year
Ambulance - Subject to medical necessity
Prescription Drugs - UD to 35 day supply
Emergency Room

*Mental health services are arranged through the Behavioral Health Network. (Age 2 and above)
+No PCP Referral is needed
Benefits are subject to $100,000 annual maximum per member, $250,000 lifetime maximum per member.

SUMMARY OF DENTAL BENEFITS

Coverage A - Delta Dental Pays 100%	Coverage B - Delta Dental Pays 50%
Diagnostic Examinations once in a 6-month period	Sealants - Children through age 14
X-rays - full mouth/panorex, x-rays once in a 3-yearperiod, bitewing x-rays once each 12 month period, x-rays of individual teeth as necessary	Restorative - Fillings
Preventive Cleanings once in a 6-month period	Oral Surgery - Surgical and routine extractions only
Fluoride once in a 12 month period through age 18	Endodontics - Root canal therapy
Space maintainers	Periodontics - Treatment of gum disease, Periodontal prophylaxis (cleaning)
	Denture Repair - Repair of removable denture to its original condition
	Emergency Treatment

*Age 2 and above

WILLIAM M. MERCER

March 24, 1998

Confidential and Proprietary

Mr. Rob Werner
Health Policy Analyst
Office of Planning and Research
New Hampshire Department of Health
and Human Services
6 Hazen Drive
Concord, NH 03301

Dear Rob:

The State of New Hampshire (State) has requested that William M. Mercer, Incorporated (Mercer), as part of its actuarial services for the State, compare the actuarial value of their Healthy Kids program with the Standard Blue Cross / Blue Shield preferred provider option (PPO) offered under the Federal Employees Health Benefit Program (FEHBP).

Mercer has determined that the aggregate actuarial value for Healthy Kids coverage is greater than the FEHBP coverage. In addition, the Healthy Kids coverage is greater than 75% of the actuarial equivalent of the FEHBP plan in the categories of prescription drugs, mental health, vision, and hearing. All actuarial computations were done in accordance with the Balanced Budget Act of 1997.

This letter details the methodology used by Mercer to compare these plans. It includes the key assumptions used to develop the comparison.

Background

The Balanced Budget Act of 1997 (BBA) allows states to expand health care coverage of children whose families' income is beyond traditional Medicaid limits for Federal funding.

The **BBA** requires that expanded children's coverage be at least as generous as a benchmark plan. The three benchmark requirements are:

1) The inclusion of basic services (inpatient and outpatient hospital, physician surgical and medical, laboratory and x-ray, and well-baby/well-child/immunization).
2) The benefit be, "at least actuarially equivalent to one of three benchmark benefit packages":
   - Federal Employee Health Benefit Program (FEHBP),

William M. Mercer, Incorporatea
2390 East Camelback Road
Suite 240
Phoenix, AZ 85016

Phone6029559682
Fax6023579573

- State employee coverage, or
- Coverage offered through an HMO plan that has the largest insured commercial enrollment in the state.

New Hampshire chose the FEHBP standard Blue Cross / Blue Shield PPO as their comparison benchmark.

3) That substantial *(75%)* actuarial value for additional services (Rx, mental health, vision, and hearing) be met.

The State is preparing their program for submittal to the Health Care Finance Administration (HCFA), and has asked Mercer to do the comparison of benefit with the FEHBP benchmark.

Information Received

Mercer received information on Healthy Kids benefit, as well as the FEHBP benefit from the State. We have attached these descriptions to this document.

Methodology

Mercer began the analysis with a pro forma of expected cost and utilization for the Healthy Kids population. The pro forma displays major categories of services and assigns a standardized average utilization and average cost to each category. The average utilization and average costs are based on standardized, privately insured children as required by the BBA. The ages are assumed to correspond with those of the Healthy Kids program. We put the benefits and cost sharing factors described above into the pro forma, and compared the resulting value of the overall benefit.

Benchmark: Federal Employee Plan

The Federal Employee Plan (FEHBP) Standard Option PPO is administered through Blue Cross and Blue Shield. For 1998, the plan has a $10 office visit copayment, a $200 hospital deductible, with 95% in network benefit after the deductible. A copy of the plan is attached.

The FEP dental benefit covers basic preventive and restorative services at a given fee schedule level. There is no coverage for major restorative and corrective services or orthodontia. A copy of this fee schedule is attached. The computed actuarial value for this plan was normalized to 100 for comparison with the Healthy Kids benefit.

Healthy Kids

Option 1 is a PCP gatekeeper plan administered through Blue Cross and Blue Shield. It includes copayments, but no deductibles or coinsurance. Option 2 was not evaluated, since it will not be part of the final Healthy Kids program. The copayment listed in Option 1 is $10, but Mercer used a $5 copay in our calculations per Rob Warner. A copy of the plan is attached.

The dental benefit is administered through Delta Dental, and claims will be paid based on usual and customary charges. Mercer used data at the 70th percentile of New Hampshire's charge distribution to represent usual and customary. The benefit covers 100% of Coverage A services, including exams and preventive services. Delta pays 50% of Coverage B services, which includes sealants, restorative services, endodontics, periodontics, denture repair, and emergency treatment. The plan does not cover major restorative services, corrective services, or orthodontic treatments.

The normalized actuarial value computed for this plan is 115, or 15% higher than the base plan.

Certification

The resulting benefit values show that the Healthy Kids benefit is richer than the FEP benefit, and meets the requirements of the BBA. We have evaluated the program for the following BBA criteria. First, all basic services are included. Second, the aggregate actuarial nvalue of the Healthy Kids plan is higher than the FEHBP benchmark. Third, the additional services (prescription drugs, mental health, vision, and hearing services) are each at least **75%** of the benchmark.

Please **call** me at **602-667-1303** if you have any questions

Sincerely

Tom Carlson, A.S.A., M.A.A.A.

TPC/JLS
G:\NHM\KIDS\Kidlettr.doc
cc: Jeff Smith

	Utilization	Hypothetical Average Cost	Healthy Kids		BlueCross FEB In Network	
			Cost Sharing	PMPM	Cost Sharing	PMPM
Inpatient Facility						
Hospital Days/1000	136	$ 900.00	$ -	$ 10.22	$ -	$ 10.22
Outpatient Facility						
Emergency Room	114	$ 150.00	$ 25	$ 1.18	$ 25	$ 1.18
Surgical/Non-Surgical	284	$ 210.00	$ -	$ 4.96	$ 50	$ 3.78
Physician						
IP Surgery	18	$ 840.00	$ -	$ 1.28	$ 175	$ 1.02
OP Surgery	210	$ 100.00	$ -	$ 1.75	$ 50	$ 0.88
Maternity Delivery	1	$ 1,500.00	$ -	$ 0.09	$ -	$ 0.09
IP Visits	83	$ 100.00	$ -	$ 0.69	$ -	$ 0.69
ER Visits	114	$ 40.00	$ -	$ 0.38	$ -	$ 0.38
Phys. Consult	47	$ 110.00	$ 5	$ 0.41	$ 10	$ 0.39
OP Visits	2,657	$ 30.00	$ 5	$ 5.54	$ 10	$ 4.43
Other						
Radiology	390	$ 50.00	$ -	$ 1.63	$ -	$ 1.63
Pathlogy	1,381	$ 10.00	$ -	$ 1.15	$ -	$ 1.15
Rx	2,836	$ 20.00	$ 7	$ 3.07	$ 10	$ 2.36
Transportation	11	$ 250.00	$ -	$ 0.22	$ -	$ 0.22
Immunization	684	$ 20.00	$ -	$ 1.14	$ -	$ 1.14
Routine Well-Baby Exams	362	$ 40.00	$ -	$ 1.21	$ -	$ 1.21
Visn/Hring/Spch/Psyc/S.A.	132	$ 40.00	$ 5	$ 0.39	$ 20	$ 0.22
Newborn Exams	38	$ 110.00	$ -	$ 0.35	$ -	$ 0.35
Physical Exams	241	$ 60.00	$ -	$ 1.20	$ -	$ 1.20
Total Medical				$ 36.87		$ 32.55
Dental				$ 5.78		$ 3.54
Total				$ 42.65		$ 36.09
			Factor	118%		100%

COMPARISON OF NH HEALTHY KIDS COVERAGE WITH
with BCBSNH FEP, NH State Employee, and N.H. MEDICAID (MA)

BENEFIT	NH Healthy Kids	BlueCross FEP	State Employees	N.H. MA
Well-child care & Immunizations	$5 copay	no copay	no copay 100%	covered
Office Visits	$10 copay	$10 copay	no copay 100%	covered
Outpatient Testing	$250 Deductible 80% of next $1,000 max $450 100% thereafter	$200 deductible 95% thereafter	no copay 100%	covered
Surgical Services, Inpatient medical care	$250 deductible 80% of next $1,000 max $450 100% thereafter	$200 deductible 95% thereafter	no copay 100%	covered
Inpatient hospital	$250 deductible 80% of next $1,000 max $450 100% thereafter	$250 deductible 100% thereafter	no copay 100%	covered
Skilled nursing Facility	$250 deductible 80% of next $1,000 max $450 100% thereafter	$200 deductible 75% thereafter	no copay 100 days per calendar year when authorized	covered with P.A.
Hospice services	$250 deductible 80% of next $1,000 max $450 100% thereafter	Hospital - 5 days 100%. Outpatient- $200 deductible, 100% thereafter.	covered with a diagnosis of less than six months to live.	non-covered (not selected)

Rob Werner
Office of Planning and Research
Susan Lombard, MAB
December 12,1997

BENEFIT	NH Healthy Kids	Blue Cross FEP	StateEmployees	N.H. MA
Home health services	20 visits $250 deductible 80% of next $1,000 max $450 100% thereafter	not covered	no copay. 100% when authorized	covered if medically necessary, private duty nursing by P.A.
PT, OT, Speech therapy	24 visits $10 copay	PT at hospital -50 visits with $200 deductible, 95% thereafter. PT at facility, $25 charge, 75% thereafter. OT, speech - 25 visits, same payment as PT.	no copay. 100% when authorized	covered up to 40 units (combined) per SFY; additional services allowed based upon medical necessity
Outpatient Mental Health	20 visits $10 copay	25 visits, $200 deductible, 60% thereafter.	20 visits per calander year. Visits 1-15, no charge. 50% of cost for visits 16-20.	covered with some limitations
Inpatient Mental Health		100 days $150 per day copay	no copy. 20 days per 12 month period.	acute care through general hospitals if medically necessary **{Further information requested through BHA}**
		not covered	no copay. Self-referral for first ten visits.	6visits/SFY,additional services allowed with authorization.

Rob Werner
Office of Planning and Research
Susan Lombard, MAB
December 12,1997

BENEFIT	NH Healthy Kids	BlueCross FEP	State Employees	N.H. MA
Eye Care	1 exam every 24 months, $10 copay 1 pr frames every 12 months, $10 copay		no copay. 1 exam every 12 months. $100 credit for presciption eyewear every 24 months.	one refraction/year covered, eyeglasses covered within guidelines
Hearing	2 hearing aids per year, $10 copay	not covered	evaluation covered when referred by PCP. Hearing aid covered by DME benefit.	evaluations are covered, hearing aid are covered within guidelines
Prescriptions	$5 generic copay $10 brand copay $5 mail order 90 day supply	$50 deductible, 80%. Mail-order $12 for 90 days	$2 generic/$6 brand name. $2 mail order for 90 day supply.	covered, no co-payments for children under age 1 years
Emergency	$25 copay	$200 deductible 95% thereafter Accidental 100% within 72 hours	$25 copay	covered
Dental	100% preventive, routine 50% restorative No orthodontics	fee schedule, no peridontics, no orthodontics.	Refer to Delta Dental benefit package.	covered
Maternity	not covered	100%	no copay, 100%	covered
Substance Abuse	not covered	same as mental health	Same as mental health for basic benefit. Diagnosis, detox, & medical treatment only. rehab not covered.	covered with limitations

Rob Werner
Office of Planning and Research
Susan Lombard, MAB
December 12,1997

COST G TABLE

BlueCross BlueShield of New Hampshire An Independent Licensee of the Blue Cross and Blue Shield Association	Option 1 PCP Provides or Arranges Care YOU PAY	Option 2 Receive Care Direct from BlueChoice Network Provider YOU PAY
Physician Services Office visits, Specialist visits. Physical exams	$10 Copayment	$15 Copayment
Well child office visit	$0	$0
Childhood immunization		
Outpatient testing		20% Coinsurance $600 maximum per member per year
Surgical services. Inpatient medical care		
Inpatient Hospital Services		
Skilled Nursing Facility and Rehabilitation Facility		
Hospice Services		
Outpatient Services		
Home Health Services — 20 visits per year		
Physical Therapy and Occupational Therapy — 24 visits per year	$10 Copayment	
Speech Therapy — 24 visits per year		
Outpatient Mental Health Services' — 20 visits per year	$10 Copayment	Not Applicable
Inpatient Mental Health Services' — 15 days per year	$0 Copayment	
Chiropractic Office Visits†	$10 Copayment	
Eyeglasses' — 1 routine eye exam per 24 months 1 pair per year (limited selection of frames)	$10 Copayment	Not Applicable
Hearing Aids' — 2 per year		
Ambulance — Subject to medical necessity	$0 Copayment	
Prescription Drugs — up to a 35 day supply	$5 Generic or Mail Order — $10 Brand	
Emergency Room	$25 Copayment ($0 if admitted)	

• Mental health services are arranged through the Behavioral Health Network (Age 2 and above)
† No PCP Referral is needed
Benefits are subject to $100,000 annual maximum per member, $250,000 lifetime maximum per member

SUMMARY OF DENTAL BENEFITS

DELTA DENTAL•
Northeast Delta Dental

Deductible: $0— There is no deductible on your Dental Plan
Calendar Year Maximum: $1,000 per person per calendar year

Coverage A — Delta Dental Pays 100%	Coverage B — Delta Dental Pays 50%
Diagnostic Examination 8 once in a 6 month period	Sealants — Children through age 14
	Restorative — Fillings
X-rays — full mouth/panorex, x-rays once in a 3-year period, bitewing x-rays once each 12-month period, x-rays of individual teeth as necessary	Oral Surgery — Surgical and routine extractions only
	Endodontics — Root canal therapy
Preventive Cleanings once in a 6-month period	Periodontics — Treatment of gum disease, Periodontal prophylaxis (cleaning)
Fluoride once in a 12-month period through age 18	Denture Repair — Repair of removable denture to its original condition
Space maintainers	Emergency Treatment

Appendix 9.10

Estimated Budget for CHIP Expansion

	0 - 1 year olds Uninsured Children	1 < 19 year olds Uninsured Children	Pregnant & < 19 Uninsured Children	Total
Phase 1:				
Federal Fiscal Year 1998 (May1, 1998)				
Enrollment: (Ave. per month)	48			48
Total Member Months	240			240
Cost per Member per Month	$ 104.50			$ 104.50
Subtotal Grants	$ 25,080.00			$ 25,080.00
Administrative costs (10%)	$ 2,786.67			$ 2,786.67
Total Expenditures	$ 27,866.67			$ 27,866.67
Federal Share (65%)	$ 18,113.33			$ 18,113.33
State Share (35%)	$ 9,753.33			$ 9,753.33
Total Revenue	$ 27,866.67			$ 27,866.67
CHIP Allotment (Federal)				$ 11,461,349.00
Surplus (Federal)				$ 11,443,235.67
Phase 2:				
Federal Fiscal Year 1999 (Oct 1, 1998)				
Enrollment: (Ave. per month)	132	2,205.50	145.75	2,483.25
Total Member Months (12mo/9mo/9mo)	1,584	19,849.5	1,311.75	22,745.25
Cost per Member per Month	$ 106.80	$ 66.50	$ 367.50	$ 96.30
Subtotal Grants	$ 169,171.00	$ 1,319,992.00	$ 482,068.00	1,971,231.00
Administrative costs (10%)	$ 18,796.78	$ 146,665.78	$ 53,563.11	219,025.67
Total Expenditures	$ 187,967.78	$ 1,466,657.78	$ 535,631.11	$ 2,190,256.67
Federal Share (65%)	$ 122,179.06	$ 953,327.56	$ 348,160.22	$ 1,423,666.83
State Share (35%)	$ 65,788.72	$ 513,330.22	$ 187,470.89	$ 766,589.83
Total Revenue	$ 187,967.78	$ 1,466,657.78	$ 535,631.11	$ 2,190,256.67
CHIP Allotment (Federal)				$ 11,461,349.00
Surplus (Federal)				$ 10,037,682.17

Notes:

0 - 1 year olds are covered as a Medicaid expansion with full Medicaid coverage.
1 < 19 year olds are covered through Healthy Kids Corp. with a federal employee actuarial equivalent benefit package.
Pregnant teens less than 19 years of age will have a full Medicaid equivalent benefit package under Healthy Kids Corp and a separate premium which is cost settled at 100% of allowable costs.
1 < 19 year old coverage begins January 1, 1999 under Phase 2.
Co-payments are not included in the costs and the cost is net of a $15 per member per month premium considered 70% collectible.
Medicaid costs are extracted from the fee for service costs of the poverty level population between 170% & 185% PL.
HKC premiums are extracted from the HKC current premiums adjusted for CHIP estimates.
Costs are inflated 2% per year.
Differences due to rounding.

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Estimated Budget for CHIP Expansion

	0 - 1 year olds Uninsured Children	1 < 19 year olds Uninsured Children	Pregnant & < 19 Uninsured Children	Total
Phase 1:				
Federal Fiscal Year 1998 (May1, 1998)				
Enrollment: (Ave. per month)	48			48
Total Member Months	240			240
Cost per Member per Month	$ 104.50			$ 104.50
Total Expenditures	$ 25,080.00			$ 25,080.00
Federal Share (65%)	$ 16,302.00			$ 16,302.00
State Share (35%)	$ 8,778.00			$ 8,778.00
Total Revenue	$ 25,080.00			$ 25,080.00
Phase 2:				
Federal Fiscal Year 1999 (Oct 1, 1998)				
Enrollment: (Ave. per month)	132	2,205.50	145.75	2,483.25
Total Member Months (12mo/9mo/9mo)	1,584	19,849.5	1,311.75	22,745.25
Cost per Member per Month	$ 106.80	$ 66.50	$ 367.50	$ 86.67
Total Expenditures	$ 169,171.00	$ 1,319,992.00	$ 482,068.00	$ 1,971,231.00
Federal Share (65%)	$ 109,961.15	$ 857,994.80	$ 313,344.20	$ 1,281,300.15
State Share (35%)	$ 59,209.85	$ 461,997.20	$ 168,723.80	$ 689,930.85
Total Revenue	$ 169,171.00	$ 1,319,992.00	$ 482,068.00	$ 1,971,231.00

Notes:

0 - 1 year olds are covered as a Medicaid expansion with full Medicaid coverage.
1 < 19 year olds are covered through Healthy Kids Corp. with a federal employee actuarial equivalent benefit package.
Pregnant teens less than 19 years of age will have a full Medicaid equivalent benefit package under Healthy Kids Corp and a separate premium which is cost settled at 100% of allowable costs.
1 < 19 year old coverage begins January 1, 1999 under Phase 2.
Co-payments are not included in the costs and the cost is net of a $15 per member per month premium considered 70% collectible.
Medicaid costs are extracted from the fee for service costs of the poverty level population between 170% & 185% PL.
HKC premiums are extracted from the HKC current premiums adjusted for CHIP estimates.
Costs are inflated 2% per year.
Differences due to rounding.

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Administration and Community Outreach

	Phase 1 FFY 1998 (May1, 1998)	Phase 2 FFY 1999 (Oct1, 1998)	Notes
Administrative:			
System Development		$ 30,000.00	MMIS modification estimated cost.
Community Outreach:			
Contracted Services	$ 2,786.67	$ 189,025.67	1998 and 1999 estimated for community outreach.
Total Admin & Outreach	$ 2,786.67	$ 219,025.67	Limited to 10% of Grant Services

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